Pharmacy Benefit News

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Specialty Spotlight

State MAC Lists Available to Everyone!

Over 30 States have published their Maximum Allowable Cost (MAC) lists for all generics. Some States publish a separate MAC list for specialty medications and others publish one integrated list. A MAC list provides the fee schedule for reimbursing generic medications. Originally, MAC lists were based on the Federal Upper Limit (FUL), but they were later expanded to cover all generic medications.

Commentary:

Maximum Allowable Cost (MAC) fee schedules are based on different models. While there is no one recognized source for modeling, common models are list below with the caveat that this list is not exhaustive:

- Spread models – commonly used by PBMs and some Plans
- Percentage models – based on overall AWP discounts
- Transparent models – commonly based on “cost plus”
- FUL-based model – based on CMS pricing including FUL, ASP, NADAC, etc.
- Combination models – based on one or more of the above

Transparency is an element of Medicare Part D and the ACA, therefore, we can expect that the general trend is away from spread models toward more transparent/FUL models where the MAC fee schedule is based on the actual cost measured as invoice cost, or as a proxy (FUL, ASP or NADAC).

Find out more

What is the Best Strategy for Lowering Blood Pressure for

What Are Information Technology (IT) Priorities for Hospitals?

The 16th annual Health Care's Most Wired Survey, conducted by *Hospitals & Health Networks* indicates that hospitals are directing IT towards data aggregation and communication. Priorities include:

- Data aggregation into community health records
- Management of care transitions
- Data aggregation of clinical and claims data accessible by the care community
- Analysis of clinical and administrative data for improving quality of care, and reducing cost
- Social media to deliver care management messages and messaging with patients

While the survey indicates various levels of uptake, the overall trends are compelling. The caveat is that the survey was directed to those hospitals that were "wired" to IT. There remains an "unwired" subset of hospitals that are not included in the survey.

Commentary:

The underlying assumption in all communications relating to data analytics and the results of analyses is that the data is valid and complete. *Valid data* implies that the fields of interest are populated and meet the validity characteristics of the data element in question, e.g., valid member ID/first and last name/DOB/gender to identify members and patients; valid NPI for provider numbers; valid ICD9/10 and CPT coding, etc. *Complete data* implies that the fields of interest are fully populated with valid data, or that the subset of valid vs. invalid data is reported. Without a statement of validity and completeness, analytics or messaging is biased and potentially misleading.

Patients with Diabetes or Kidney Disease?

A network meta-analysis in the *Lancet* provides some clarity to guiding decisions about lowering blood pressure in patients with diabetes and chronic kidney disease (CKD).

"Researchers examined nearly 160 randomized trials that compared different BP-lowering regimens in over 40,000 adults with diabetes (mostly type 2) and CKD. They found that no drug was better than placebo in terms of survival. ACE inhibitors, angiotensin-receptor blockers (ARBs), and endothelin inhibitors were most effective for preventing end-stage renal disease; however, only ARBs were significantly superior to placebo."

"ACE inhibitor plus ARB combination therapy was associated with a "borderline" increased risk for hyperkalemia and acute kidney injury. The authors estimate that for every 1000 patients who receive this combination for 1 year, 14 patients might avoid end-stage kidney disease and 208 may have regression of albuminuria — but 55 could develop acute kidney injury, and 135 could experience hyperkalemia. (The benefits and harms after 1 year of ARB monotherapy were lower.)"

Sources:

1. *Lancet article (Free abstract)*
2. *Background: NEJM Journal Watch General Medicine coverage of JNC 8 hypertension guidelines (Free)*

Commentary:

We included this study in the PBN because it leads to several educational issues of interest. First, while the study results favor ARBs, favoritism is measured by an "odds ratio". The study identified that with ARB alone, the odds ratio was 0.77; and with ARB + ACE inhibitor, the odds ratio was 0.62. The closer to 1.0 is more certain, but the difference between the two odds is only 0.15 for a required change in kidney filtering function (GFR) of approximately < 90ml/min to < 15ml/min for a standard individual (1.73m2).

Second, the combination of ACEI plus ARBs is only recommended for New York Heart Association (NYHA) stages 3 and 4, which are the most severe forms of heart failure, not hypertension. Third, the risks of developing kidney disease (CKD) are not the same for all patients in that the severity of hypertension and other co-morbid conditions are more reflective of which patients will develop or decompensate to CKD 3-5, i.e., the more severe forms of CKD. Thus, the meta-analysis indicates some interesting findings that require more study before the results can be used in clinical practice. The meta-analysis also provides some interesting educational pearls.

Operational Strategy & Strategic Implementation
Services Available!

- Pharmacy Benefit Analysis, Review and Recommendations
- PBM/Specialty Medication Contract Review and Negotiations
- Analytics Review of Findings, Explanations and Recommendations

Specialty pharmacy presents a critical need for contracts that provide cost and utilization management. While PBM and Health Plan contracting may lead to savings at point-of-sale or through rebates, member cost share is so large that contracts require an expanded vision for all stakeholders and benefit designs.

Further, claims processing is an integral part of the contract to ensure that cost of care is not expanded by inaccurate coding.

Yet even with optimal contract language for cost control, utilization management is the second critical component that offers assurance for optimal specialty medication usage for the correct diagnosis, dose, frequency and duration of therapy.

Pro Pharma has extensive experience is claim coding, processing, utilization management and design of contracts to reflect best practices for specialty pharmacy.

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Pro Pharma Pharmaceutical Consultants, Inc.
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